Manaaki Pakeke

Te Kaunihera Māori o Aotearoa
New Zealand Māori Council

Author: Matthew Tukaki, Executive Director of the New Zealand Maori Council, Member of the National Executive and Chair of the National Executive of the Tamaki District of Council

New Zealand Maori Council Policy Statement: Maori and our Aging Population

Contents

Introduction and overview 2

Why its important to understand the differences between urban and regional environments? 4

The business case for a clear and specific focus 5

Investing more in Kaumata Housing and Housing attached to Marae 5

Development of care support networks within communities for health and welfare checks 5

Increased investment in mobile health units 6

Additional health promotion campaigns around preventive health checks 6

Investing in additional supplementary allowances and financial support for elders looking after mokopuna 7

Dedicated support for Maori with a disability or intellectual disability as they age 8

More investment support for Marae and Iwi Health and Social Service around infrastructure in rural and regional areas 8

About the New Zealand Maori Council

The New Zealand Maori Council is one of the oldest of all Maori representative groups established through the Maori Community Development ACT (1962). In recent times Council has increased its focus on social challenges and issues that impact Maori and, as a result, its work programs have changed to developing idea and innovative ways of reducing barriers that might be in the way of our people progressing forward.

About this Policy Statement

A New Zealand Maori Council Policy Statement is intended to provide direction and narrative to the sixteen Districts of the New Zealand Maori Council when it comes to a specific kaupapa. The Statements also guide the National Executive of Council when advocating on behalf of a specific kaupapa while also providing the Crown and stakeholders with an insight into the position we may take. Each policy statement has been researched, socialized in the context of feedback and tested through surveys, desktop reviews of currently available literature and through feedback from within the Council.

Introduction and overview

Our Maori population is expected to grow significantly over the coming decades to between 830,000 -910,000 in 2025 to 1.118 million by 2038. This is a due to a number of factors from increases in birth rates to an increase in those who identify as Maori through descent. In terms of the latter, thousands more New Zealanders are undertaking to understand more about their whakapapa with some finding a Maori connection by way of descent. This is a remarkable turn around in population growth from less than 50,000 in the 1800's. While the Maori population has a much younger age profile compared to non-Maori there will be a increase in those reaching those latter years. In 2013, life expectancy at birth was 73.0 years for Māori males and

77.1 years for Māori females; it was 80.3 years for non-Māori males and 83.9 years for non-Māori females.

Other important facts that have guided the development of this policy document are health indicators. These indicators are important to understand when it comes to aging because it sets the scene for what additional support and considerations may be needed when it comes to the health of the aging Maori population:

- Māori had a higher disability rate than non-Māori, regardless of age, in 2013. Older people had higher disability rates generally.
- The heart failure mortality rate among Māori was more than twice as high as that of non-Māori), and Māori were about 4 times as likely as non-Māori to be hospitalized for heart failure. The disparity was greater for females: the heart failure hospitalization rate among Māori females was about 4.5 times as high as that among non-Māori females
- the most common cancers registered for Māori females over this time period were breast cancer, lung cancer, colorectal cancer, uterine cancer and cervical cancer. Figure 9 shows that the leading causes of cancer death for Māori females were lung cancer, breast cancer, colorectal cancer, stomach cancer and uterine cancer.
- The most common cancer registration sites for Māori males were prostate cancer, lung cancer, colorectal cancer, liver cancer and stomach cancer (Figure 10). The leading causes of cancer mortality for Māori males were lung cancer, colorectal cancer, prostate cancer, liver cancer and stomach cancer.
- The chronic obstructive pulmonary disease (COPD) mortality rate among Māori aged 45 and over in 2010–12 was almost 3 times that of non-Māori in the same age group
- The disparity was greater for females: Māori females had a COPD mortality rate almost 3.5 times that of non-Māori females
- Data from the Ministry of Health shows that the self-reported prevalence of diabetes[2] among Māori was about twice that of non-Māori in 2013/14.It also shows that there are much higher disparities between Māori and non-Māori for diabetes complications.
- Renal failure is one of the complications of diabetes. Rates of renal failure with concurrent diabetes for Māori aged 15 and over were more than 5 times that of non-Māori at the same age group in 2012–14. While some of this difference can be attributed to the higher prevalence of diabetes among Māori, the disproportionately higher rate suggests that Māori with diabetes are more likely to have renal failure than non-Māori with diabetes. The extent of the disparity can be estimated by dividing the relative risk of renal failure by the relative risk of prevalence (i.e., 5.55 ÷ 1.99), which suggests that among people with diabetes, Māori are 2.8 times as likely as non-Māori to have renal failure.
- Lower limb amputation is another complication of diabetes. Similarly, rates of lower limb amputation with concurrent diabetes for Māori were over 3 times that of non-Māori in 2012–14. Therefore, among people with diabetes, lower limb amputations among Māori can be estimated as 1.7 times that of non-Māori (i.e., 3.44 ÷ 1.99).

- Among adults with natural teeth, Māori adults were more likely than non-Māori to report that they had never visited a dental health care worker at all, or usually only visited a dental health care worker for dental problems

Facts around Maori financial insecurity and housing in retirement:

1. Maori are four times more likely than non-Maori to have little or no financial savings heading into retirement / more likely to be reliant on national super
2. Maori are more likely to not own their own home in retirement – instead the asset is owned by a central or local Government authority (such as Housing New Zealand) although there is an increase in the supply of Iwi provided and supported housing for Kaumatua and Kuia
3. Maori are five times more likely than non-Maori to head into retirement with a higher debt to savings ratio
4. Maori are more likely to look after their Mokopuna on a full time or more than part time basis into retirement – where the child or children will be living with them

All in all, Maori are more likely to enter into retirement with higher need and reliance on the public health system, fewer savings and assets as well as a higher than average connection to the child and state care system through the care of their grandchildren. In addition is the need to understand that as the population grows more and more Maori will move into retirement and their latter years in poverty and the need to address, plan and prevent this happening will require a number of policy levers and greater investment in Maori aged care support and supplementary services.

Why its important to understand the differences between urban and regional environments?

The population dynamic within Maoridom is complex but it is generally accepted that more of our people live in urban centers or in the North Island. All of that aside what is little understood is the accessibility of service difference between our cities and the regions. For example, hospitals in the main urban centers are better staffed and equipped with the latest in technology and infrastructure with higher than average support to patient ratios. In the regions a patient is less likely to be able to access state of the art equipment and treatments and therefore will have to travel to an urban center at both greater time and expense. This is also true of secondary and supplementary services such as dental care and oral health, mental health and so on. In addition to this is the availability of emergency services to respond when it comes to critical care or events – heart attacks, stroke and so on. The reality is we have less accessibility when it comes to regional infrastructure compared to urban. This is also true of the disability services and support sector – Maori who have a physical or intellectual disability are less likely to be able to access support services compared to them living in an urban environment. It should though be noted that services might be available through a mix of service providers from Iwi and private through to District Health Boards and Hospitals doesn't mean they are timely. Therefore, it is important to understand the differing needs of access for an aging population from urban to regional areas.

The business case for a clear and specific focus

There is currently no national plan of action or policy when it comes to an aging Maori population nor are their specific or coordinated approaches to care support and planning. There are programs that work in isolation but, primarily, they operate in silos between Government agencies and service providers. For example, Oranga Tamariki may be the specific touch point for a grandparent caring for a mokopuna but there is little or not connection with other agencies who might also be supporting them from Health and Welfare to education and so on. A clear strategy covering a multitude of points and areas must be our focus if we are also going to bridge the gap of life expectancy. This policy document is in no way intended to be a complete "fix" to the challenge, but it is intended to kick start the conversation of where we need to go and how we might get there. Assisting in the development of this document is data from the Ministry of Health, Statistics New Zealand and published data sets from MBIE and other agencies. Snapshot data has also been used from not-for-profit service providers and Iwi data where available. In addition to this a survey was developed and sent to 150 Maori identified as being in the age brackets of 55-65 and 65 and above. The demographic was split between those in an urban environment and those living in regional or provincial New Zealand. In the first group (55-65) there was a response rate of 56% while in the second (65 and above) there was a response rate of 43%. Also informing this policy document are a collection of interviews with elders from both a city and regional environment that looked at both the challenges and opportunities around aging.

Investing more in Kaumata Housing and Housing attached to Marae

Our people have said they feel most comfortable and connected when they are connected to a community, they feel a part of and can contribute to. For Maori that is very much the Marae environment. A number of Maori spoken to in the urban environment have a connection with home but often it is not the same as having lived there. As mentioned earlier the number of our people who have moved to the cities over many decades were in search of work to live but remained connected to home through land or family ties. Many of our people also believe that being "around" or connected to their Marae would be an opportunity to being socially connected and engaged as well as being able to contribute through volunteering. Others have said that it is an opportunity for them to learn Te Reo and more about their whakapapa into retirement that they haven't otherwise had the chance to do while working. For those who were attached to the Marae currently their reasons were very much the same. The challenge is affordability of housing and its availability. That is why, whether in an urban or regional setting, more investment needs to be made in Kaumatua housing attached to Marae complexes that also provide those Marae with the opportunity to further develop and build their own infrastructure and services. This investment could be actioned through a national housing plan that provides the capital necessary to develop housing projects around a dedicated care and support service model. This should be extended to those who currently look after their Grandchildren who would also have access to a greater level of care and support services. The housing should be specifically able to ensure a high quality of life and increase access to primary and secondary health services.

Development of care support networks within communities for health and welfare checks

There is clearly a need to ensure that we care for people in the community in a much more structured way. This includes driving further investment into Iwi and Hapu health and social services to increase the

frequency of in-home visits from both a health and well-being perspective. This means also providing for greater investment in infrastructure but also looking at new and innovative approaches to how we tailor care. One such approach is to coordinate the different departmental or agency approaches into a single care package with an associated fixed budget per annum. The package would include the cost of care and welfare visits, transportation to and from medical appointments and social activities, assistance with lawn mowing or upkeep as well as equipment for the home. Importantly control over how the budget in the package would be spent could be developed through a joint care plan between the elder and the respective agency responsible for managing it. Importantly this would provide budgetary forecasting around the cost per person as the population ages. In addition to this would be the provision and funding for a full-time resource in demand and need locations to act as a care and support coordinator within local Iwi and Hapu.

Increased investment in mobile health units

Getting to a Doctors visit can be a tough challenge for many people as they age. This includes access to available transportation or the availability of a medical professional. In our regional centers it is tough to access adequate professional care and diagnosis when needed and so diagnosable disease festers and grows worse. Our people tell us that they only seek medical help or intervention when it is often too late. That is why the New Zealand Maori Council believes that there should be greater investment driven into access through mobile health units. This means expanding the notion of a breast cancer screening mobile unit to also include other services built around early diagnosis and prevention. At its optimum these units should be assets of Iwi and Hapu and, therefore, investment should be driven into both developing it as a program as well as a local workforce from both a regulated and unregulated perspective.

Additional health promotion campaigns around preventive health checks

We know that when the right messages are sent by the right people and organisations who are trusted by Maori, the message is heard. It is imperative that nationally developed campaigns are built by Maori and for Maori to better empower our people to prevention and early diagnosis. This is particularly important for our elders as many health promotion campaigns tend to target people in their early years. Our approach, and recommendation, is to build simple campaigns across a number of fronts. The first is focused on prevention and seeking help early on. If you think something might be wrong don't be afraid to get it checked out – clear and concise messaging in both Te Reo Maori and English can see an increase in the number of our people seeking help. Also, targeting Maori males in the latter years would see campaigns being run targeting whanau and partners to urge them to get checks while also running the campaigns in places where they meet. In addition to these sorts of campaigns are those around elder abuse and social isolation. While it is unknown exactly that the extent of elder abuse in Maori communities is the rule of thumb should be try and make people aware to either prevent it from becoming a problem or bring down the number of incidents that may have been reported.

Investing in additional supplementary allowances and financial support for elders looking after mokopuna

Māori Council calls for a vulnerable whanau and families support package – it's time to recognise the contribution of our elders in the care and protection of our children. When it comes to the care and protection of our children the harsh reality is that our elders are the ones providing care. We need to recognise the contribution they make, and we need to do something about it. It is the intention of Council to continue to push for additional support specific to whanau.

The New Zealand Māori Council estimates that there are more than 50,000 such carers across the nation who, unpaid, provide a system of care that is not monetarily valued by the State but is often accessed and used as part of the childcare and protection system. If you were to take a standard working week for a carer and calculate it at 38.5 hours work at $20 per hour the net annual cost of providing that care would amount to $40,040.00 per annum. We estimate more than $2 billion in voluntary forms of care is provided by elderly New Zealanders each year proving a significant cost saving to the taxpayer and Agencies. Yet, little of this service is recognized - instead we continue to turn to these people for additional care in some of the most complex and complicated of situations.

And by carers we mean not just Māori but non-Māori as well. When we look at the childcare and protection system in New Zealand the standout figure must be the number of children who are in the care of extended whanau and, in particular, our elders. Increasingly more of our elders are taking on the task of caring and looking after their grandchildren as their own children face challenges from mental health issues, incarceration and high levels of addiction to drugs and alcohol. Many of these elders are meant to be enjoying their later years of retirement but instead a thrust into bringing up children all over again – and this time with the added pressure and stress of finances and cashflow. Even for those who are still working the challenge of putting kai on the table, providing clothing, the basic tools to attend school such as uniforms and stationery can be a burden. And while many press ahead they do so by using what little resources they have and with very little in the way of additional support. Even for those who are caring for mokopuna who are not currently able to access support because of their specific circumstances the financial stress and pressure can be too much.

That is why the New Zealand Māori Council believes that one of the circuit breakers we need to look at as a Government is about providing additional taxation relief and exemptions to our carers over the age of 55. We have called it the vulnerable whanau and family tax exemption and support package that would be applicable to all New Zealanders both Māori and non-Māori. This includes additional tax exemptions for working grandparents per school aged child (Per annum) of $200 for school uniforms and stationery (or related supplementary allowance), a further energy supplement of $150 per household per annum and a supplementary allowance of $500 per annum to assist with kai. The total package would cost on average $850 per annum and could be administered by the Ministry of Social Development as a series of additional supplementary allowances or additional deductions at tax time across those categories. In addition, we feel that there needs to be a review of carers allowances for those in retirement to supplement national superannuation to bring it in line with the relative cost of living.

Dedicated support for Maori with a disability or intellectual disability as they age

Often forgotten is a group of silent New Zealanders – Maori living with a physical or intellectual disability. We know that often these people are cared for by Whanau, but we also know those living in the regions have little access to daily support or supplementary services. When it comes to Maori living with a physical disability, they often become isolated to their home while some can also be homeless. A recent survey of the homeless in Auckland found that a great many of those living on the streets with a form of disability were Maori. Anecdotal evidence suggest that a great many of our people living rough or homeless are those over the age of fifty. Then there are those Maori living with a form of intellectual disability or mental health condition. Currently there is no national strategy or approach to either identify specifically where these people are what specifically their needs might be. What we do know, and is clear, is that these people are more likely to be isolated, forgotten or unable or unlikely to access the care and support services they need to continue living long and healthy lives or living securely in their latter years. The policy of the New Zealand Maori Council is to work with agencies and Government to seek to build a national strategy around what to do, how to do it and where. This includes a more holistic approach to better access to housing both in the urban and regional setting.

More investment support for Marae and Iwi Health and Social Service around infrastructure in rural and regional areas

Underpinning this policy is to support the needs of Iwi Health and Social Services organisations in both an urban and regional setting. Evidence tells us that services provided by and for Maori are more likely to be successful around both participation and engagement. The challenge has always been the investment available not just to develop and run programs but also the funds available to build a strong and agile back end and infrastructure. It is one thing to develop a program it is another to ensure that investment has also been made in infrastructure to deliver it and back end support structures to administer it. Traditionally Government departments fund program related activities without considering the need to collect data, hold and retain records with sensitive data, reporting or the IT support and structures to manage it. At the other end advances in medical technology also require a stream of ongoing investment to allow Hauora and health services to keep up with mainstream providers. This could be everything from dentistry and oral health technology to items related to dialysis and cancer care. Therefore, the New Zealand Maori Council will be advocating for two key changes. The first is related to the procurement framework of health funding and provisioning. The second will be the establishment of a dedicated health infrastructure fund for Iwi and Hapu to access based on both demand and need.

Closing statement

The New Zealand Maori Council is not a front-line service provider – instead we are a strong advocate for the affairs of Maori. Our role, under the Maori Community Development Act (1962) Is to represent those views to the benefit of all Maori, wherever they may be. In today's world it is also to ensure that our people can thrive, to live long and healthy lives, to be active participants in the Te Ao Maori world and have every chance and opportunity of success. Our role is also to support Maori organisations

whether they be tribal, Iwi or Hapu related, Maori small business, Maori industry and Maori service providers.

Data sources

- The New Zealand Ministry of Health
- The Ministry of Maori Development, Te Puni Kokiri
- Statistics New Zealand
- The New Zealand Human Rights Commission
- The World Health Organisation